Achieving Health Equity

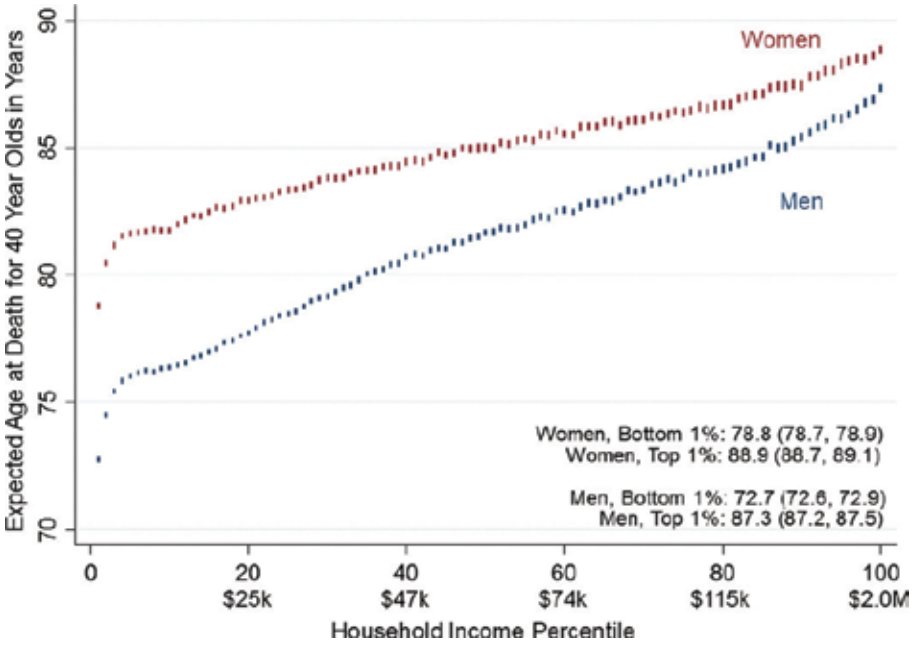
A person's health, and ability to make healthy decisions, is impacted dramatically by where they live, their income, their educational attainment and their racial and ethnic status.

Americans in the top 1 percent of household income live 10-15 years longer than those in the bottom 1 percent.[772] Adults without a high school diploma are three times more likely to die before the age of 65 than those with a college degree.[773] On average, the life expectancy for Black men is 4.5 years shorter than for White men; and 3 years shorter for Black women than White women.[774]

The causes of health inequities are multifaceted and often intertwined with lower socioeconomic status and differential access to opportunities and factors that influence health, such as quality healthcare, income, education, housing, transportation and others. For instance, access to safe parks, supermarkets and quality housing provide significant opportunities to be healthier.[775]

Blacks and Latinos have lower median household incomes than Whites and are more likely to live in poverty.[776] Black men earned 70 cents for every dollar earned by White men in 2014 and Hispanic men earned 60 cents on the dollar.[777, 778] People living in neighborhoods with high levels of poverty have a higher risk of less healthy behaviors — such as smoking, physical inactivity or poor nutrition — related to inequities in the physical and social environment.[779] Low-income neighborhoods, for example, are less likely to have places where children can be physically active or have access to fully-stocked supermarkets with healthy, affordable foods — contributing to higher rates of obesity and poor nutrition in these communities.[780, 781, 782] Low-income and minority communities also experience higher air pollution, which affects respiratory and cardiovascular health, as well as birth outcomes.[783]

THE RELATIONSHIP BETWEEN LIFE EXPECTANCY AND INCOME BY GENDER, U.S. 2001-2014 [771]

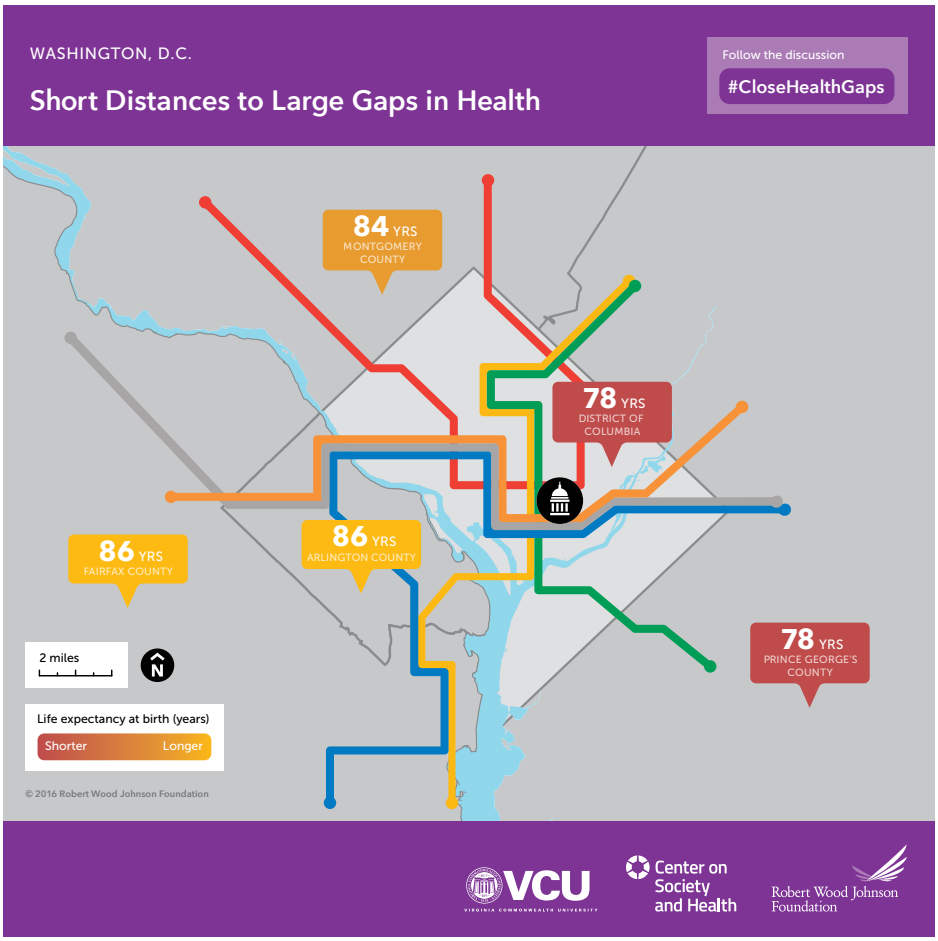


Source: Chetty et al., 2016

Health inequities have a high economic cost. A study by the Urban Institute found that the differences in rates among Blacks, Hispanics and Whites for a set of preventable diseases (diabetes, heart disease, high blood pressure, renal disease and stroke) cost the healthcare system $23.9 billion annually.[784] By 2050, this is expected to double to $50 billion a year.[785] Eliminating health inequalities could lead to reduced medical expenditures of $54-61 billion a year, and recover around $13 billion annually due to work lost by illness and around $240 billion per year due to premature deaths (2003-2006 spending).[786, 787] According to CDC, the rate of preventable hospitalizations for Blacks is almost double that of Whites — which contributes to over a half million hospitalizations and $3.7 billion in hospitalization costs annually.[788]

Examples of some health inequities include:

- American Indians and Alaska Natives are twice as likely to have diabetes as Whites, and diabetes rates among Blacks and Hispanics are over 1.5 times higher than for Whites.[789]



- Blacks have the highest death rate and shortest survival of any racial and ethnic group in the United States for most cancers.[790]
- Black women with breast cancer are 40 percent more likely to die than White women with breast cancer, despite similar incidence rates of the disease.[791, 792]
- Black men are about twice as likely to die from prostate cancer as Whites. [793]
- Hispanic women are more than 1.5 times as likely to have cervical cancer as Whites.[794]
- Infants born to Black women are 1.5 to almost 3 times more likely to die than infants born to women of other races/ethnicities regardless of education level.[795] American Indian and Alaska Native infants die from Sudden Infant Death Syndrome (SIDS) at about twice the rate of White infants.[796]
- Asthma rates for Black children grew by 50 percent between 2001 and 2009, while the overall asthma rates increased 15 percent.[797] Disparities in asthma rates between Black and White children reached a peak in 2011 (with Black children twice as likely as White children to have asthma).[798] And, asthma-related hospitalizations and deaths are over twice as high among Blacks as Whites.[799, 800]
- Black and Latinos have less access to regular healthcare and receive lower quality care on about 40 percent of core healthcare measures.[801]
- In addition, Blacks and Hispanics were more likely than Whites to report poor communication from healthcare providers.[802] Some examples of implicit bias in healthcare identified by The Joint Commission, Division of Health Care Improvement include: non-White patients receive fewer cardiovascular interventions and renal transplants; Black women are more likely to die after being diagnosed with breast cancer; non-White patients are less likely to be prescribed pain medications; Black men are less likely to receive chemotherapy and radiation therapy for prostate cancer; and patients of color are more likely to be blamed for being too passive about their healthcare.[803]

RECOMMENDATIONS

- **Create strategies to optimize the health of all Americans, regardless of race, ethnicity, income or where they live.** The country must invest in first understanding the systematic disparities that exist and the factors that contribute to these differences, including poverty, income, racism and environmental factors. Resources must then be devoted to implement community-driven approaches to address these factors, including using place-based approaches to target programs, policies and support effectively.

- **Expand cross-sector collaborations addressing health equity.** Improving equity in health will require supporting and expanding cross-sector efforts to make communities healthy and safe. Efforts should engage a wide range of partners, such as schools and businesses, to focus on improving health through better access to high-quality education, jobs, housing, transportation and economic opportunities.[804]

- **Fully fund and implement health equity, health promotion and prevention programs in communities.** Partner with a diverse range of community members to develop and implement health improvement strategies. Federal, state and local governments must engage communities in efforts to address both ongoing and emergency health threats. The views, concerns and needs of community stakeholders, such as volunteer organizations, religious organizations and schools and universities must be taken into account in this process. Proven, effective programs, such as REACH (Racial and Ethnic Approaches to Community Health) should be fully-funded and expanded.

- **Collect Data on Health and Related Equity Factors by Neighborhood:** Improving data collection at a very local level to make connections between health status and equity concerns can help identify concerns and inform the development of strategies to address them. Collecting and reporting data by neighborhood at a zip code or even more granular neighborhood level are essential to understanding inequity concerns.

- **Support Medicaid coverage and reimbursement of clinical-community programs to connect people to services that can help improve health.** Medicaid should reimburse efforts that support improved health beyond the doctor's office — programs such as asthma and diabetes prevention and care management, and community-based initiatives, can help better address the root causes that contribute to inequities.

- **Communicate effectively with diverse community groups.** Federal, state and local officials must design culturally competent communication campaigns that use respected, trusted and culturally competent messengers to communicate their message. Communication channels should reflect the media habits of the target audience.

- **Prioritize community resiliency in health emergency preparedness efforts.** Federal, state and local government officials must work with communities and make a concerted effort to address the needs of low-income and minority groups during health emergencies. Public health leaders must develop and sustain relationships with trusted organizations and stakeholders in diverse communities on an ongoing basis—including working to improve the underlying health of at-risk communities, so these relationships are in place before a disaster strikes. Communication and community engagement must be ongoing to understand the disparate needs of various populations.

- **Eliminate racial bias in healthcare.** Policies should incentivize equity and penalize unequal treatment in healthcare, and there should be increased support for programs to increase diversity across health professions. Some of The Joint Commission's recommendations for combatting implicit bias include: assiduously practicing evidence-based medicine; supporting cultural understanding and avoiding stereotypes; supporting the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care; and supporting techniques that de-bias care, including through training, perspective-taking, emotional expression and counter-stereotypical exemplars.[805]

Endnotes

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